Lilburn Eyecare & Optical Center

Your Vision Source

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RECORDS RELEASE REQUEST **TODAYS DATE**_____

Patient Name: _____ **Date of Birth:** _____

_____**Patient requesting Their Own Records**

_____**Patient picking up** _____ **Mail to Patient**

Address: _____

City: _____ **State:** _____

Zip: _____ **Phone #:** _____

Sig. of Patient/ Parent/ Guardian: _____

_____**We are Requesting Records from another Doctor**

_____**By Mail** _____ **By Fax**

Name of Physician Records Being Requested From: _____

Clinic Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone # _____ **Fax #** _____

Sig of Patient/ Parent/ Guardian: _____

_____**Patient is Requesting Our Records to be sent to another Doctor**

_____ **By Mail** _____ **By Fax**

Name of Physician Records being sent to: _____

Clinic Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ **Fax #:** _____

Sig of Patient/Parent/Guardian: _____

Date Records Mailed or Faxed _____ **Staff Initials:** _____